

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>203</u>	Skilled (SNF)	<u>203</u>	<u>74,298</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>203</u>	TOTALS	<u>203</u>	<u>74,298</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>18,365</u>	<u>1,762</u>	<u>628</u>	<u>20,755</u>	8
9	SNF/PED					9
10	ICF	<u>42,852</u>	<u>4,112</u>	<u>1,464</u>	<u>48,428</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>61,217</u>	<u>5,874</u>	<u>2,092</u>	<u>69,183</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.12%D. How many bed-hold days during this year were paid by Public Aid?
1,016 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/AF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 04/01/93J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 04/01/93 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 23 and days of care provided 1,140Medicare Intermediary AdminaStar - Kentucky

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MAPLEWOOD CARE, INC.

0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
1	Dietary	204,559	20,083	35,511	260,153		260,153	(17,589)	242,564			1
2	Food Purchase		267,386		267,386	(26,747)	240,639	(226)	240,413			2
3	Housekeeping	229,746	26,279		256,025		256,025	613	256,638			3
4	Laundry	35,586	21,397		56,983		56,983		56,983			4
5	Heat and Other Utilities			145,890	145,890		145,890	2,281	148,171			5
6	Maintenance	39,403		132,168	171,571		171,571	(18,693)	152,878			6
7	Other (specify):*							5,132	5,132			7
8	TOTAL General Services	509,294	335,145	313,569	1,158,008	(26,747)	1,131,261	(28,482)	1,102,779			8
9	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,356,470	89,862	660,513	2,106,845		2,106,845	(25,495)	2,081,350			10
10a	Therapy	121,910		10,157	132,067		132,067		132,067			10a
11	Activities	89,993	15,543	2,454	107,990		107,990		107,990			11
12	Social Services	139,424		4,790	144,214		144,214		144,214			12
13	Nurse Aide Training			558	558		558		558			13
14	Program Transportation			1,259	1,259		1,259		1,259			14
15	Other (specify):*							3,288	3,288			15
16	TOTAL Health Care and Programs	1,707,797	105,405	685,731	2,498,933		2,498,933	(22,207)	2,476,726			16
17	C. General Administration											
17	Administrative	60,174		119,228	179,402		179,402	1,252	180,654			17
18	Directors Fees											18
19	Professional Services			183,197	183,197		183,197	(106,726)	76,471			19
20	Dues, Fees, Subscriptions & Promotions			50,735	50,735		50,735	(22,514)	28,221			20
21	Clerical & General Office Expenses	96,246	23,691	94,020	213,957		213,957	(9,343)	204,614			21
22	Employee Benefits & Payroll Taxes			301,208	301,208	26,747	327,955		327,955			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,132	3,132		3,132	785	3,917			24
25	Other Admin. Staff Transportation			1,889	1,889		1,889	3,322	5,211			25
26	Insurance-Prop.Liab.Malpractice			85,798	85,798		85,798	1,027	86,825			26
27	Other (specify):*							25,238	25,238			27
28	TOTAL General Administration	156,420	23,691	839,207	1,019,318	26,747	1,046,065	(106,959)	939,106			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,373,511	464,241	1,838,507	4,676,259		4,676,259	(157,648)	4,518,611			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

MAPLEWOOD CARE, INC.
0040428
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V
LINE #

22	EMPLOYEE BENEFITS	26,747	
2	FOOD		26,747

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number **MAPLEWOOD CARE, INC.**

#0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			114,673	114,673		114,673	299,222	413,895			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			122,390	122,390		122,390	1,126,820	1,249,210			32
33	Real Estate Taxes			90,594	90,594		90,594	4,654	95,248			33
34	Rent-Facility & Grounds			1,076,929	1,076,929		1,076,929	(1,076,929)				34
35	Rent-Equipment & Vehicles			8,932	8,932		8,932	9,594	18,526			35
36	Other (specify):*							9,920	9,920			36
37	TOTAL Ownership			1,413,518	1,413,518		1,413,518	373,281	1,786,799			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		29,956	73,064	103,020		103,020	(1,332)	101,688			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,448	111,448		111,448		111,448			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		29,956	184,512	214,468		214,468	(1,332)	213,136			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,373,511	494,197	3,436,537	6,304,245		6,304,245	214,301	6,518,546			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer- ence	OHF USE ONLY	
1	Day Care			1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals			4
5	Telephone, TV & Radio in Resident Rooms			5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients			8
9	Non-Straightline Depreciation	(14,844)	30	9
10	Interest and Other Investment Income	(33)	32	10
11	Discounts, Allowances, Rebates & Refunds			11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax	(226)	2	13
14	Non-Care Related Interest			14
15	Non-Care Related Owner's Transactions			15
16	Personal Expenses (Including Transportation)			16
17	Non-Care Related Fees			17
18	Fines and Penalties			18
19	Entertainment			19
20	Contributions	(110)	20	20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainers			22
23	Malpractice Insurance for Individuals			23
24	Bad Debt	(56,140)	21	24
25	Fund Raising, Advertising and Promotional	(15,631)	20	25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,000)	21	26
27	Nurse Aide Training for Non-Employees			27
28	Yellow Page Advertising	(5,010)	20	28
29	Other-Attach Schedule	(32,428)		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (130,422)		\$ 30

OHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)	344,723	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 344,723	36
	(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 214,301	37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

	1	2	3	4	
	Yes	No	Amount	Reference	
38			\$		38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47			\$		47

Report Period Beginning: 01/01/00
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Deferred Maintenance	\$ 830	6 1
2	Trust Fees	(150)	20 2
3	Secretary of State	(200)	20 3
4	Cigarettes	(223)	10 4
5	Non Allowable Legal Fees	(18,413)	19 5
6	Amortization Expense - Bldg Co.	(6,667)	31 6
7	Political Contributions COPE	(297)	20 7
8	Capitalized Repairs & Maintenance	(3,144)	6 8
9	HCTA- Civil Monetary Payment	(2,600)	20 9
10	Comission on Pay Phone	(293)	21 10
11	Maplewood, LLC Late Fee Expense	(1,271)	21 11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49			49
50			50
51			51
52			52
53			53
54			54
55			55
56			56
57			57
58			58
59			59
60			60
61			61
62			62
63			63
64			64
65			65
66			66
67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(32,428)	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(21,180)			3,591				(17,589)	1
2	Food Purchase	(226)											(226)	2
3	Housekeeping			613									613	3
4	Laundry													4
5	Heat and Other Utilities			827	1,454								2,281	5
6	Maintenance	(2,314)		510	(11,427)	(5,462)							(18,693)	6
7	Other (specify):*				780	4,352							5,132	7
8	TOTAL General Services	(2,540)		1,950	(9,193)	(22,290)			3,591				(28,482)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(223)			(20,773)				(4,499)				(25,495)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,288								3,288	15
16	TOTAL Health Care and Programs	(223)			(17,485)				(4,499)				(22,207)	16
	C. General Administration													
17	Administrative			14,307	(63,485)	45,807		4,623					1,252	17
18	Directors Fees													18
19	Professional Services	(18,413)		(86,502)	(14,056)	12,227		18					(106,726)	19
20	Fees, Subscriptions & Promotions	(23,998)		368	1,104			12					(22,514)	20
21	Clerical & General Office Expenses	(63,704)	1,271	47,506	5,558			26					(9,343)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			187	598								785	24
25	Other Admin. Staff Transportation			651	2,671								3,322	25
26	Insurance-Prop.Liab.Malpractice			417	588			22					1,027	26
27	Other (specify):*			7,463	4,926	12,327		522					25,238	27
28	TOTAL General Administration	(106,115)	1,271	(15,603)	(62,096)	70,361		5,223					(106,959)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(108,878)	1,271	(13,653)	(88,774)	48,071		5,223	(908)				(157,648)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(14,844)	305,524	3,049	5,493								299,222	30
31	Amortization of Pre-Op. & Org.	(6,667)	6,667											31
32	Interest	(33)	1,122,393	1,190	3,253			17					1,126,820	32
33	Real Estate Taxes			1,539	3,115								4,654	33
34	Rent-Facility & Grounds		(1,076,929)										(1,076,929)	34
35	Rent-Equipment & Vehicles			2,631	6,651			312					9,594	35
36	Other (specify):*		9,920										9,920	36
37	TOTAL Ownership	(21,544)	367,575	8,409	18,512			329					373,281	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(1,332)				(1,332)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers								(1,332)				(1,332)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(130,422)	368,846	(5,244)	(70,262)	48,071		5,552	(2,240)				214,301	45

VII. RELATED PARTIES
A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule		See Schedule Attached		See Schedule Attached		
				MAPLEWOOD, LLC		BUILDING COM

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	Rent Income	\$ 1,076,929	Maplewood, LLC	100.00%	\$	(1,076,929)	1
2	V	32	Interest Expense		Maplewood, LLC	100.00%	1,122,393	1,122,393	2
3	V	30	Depreciation		Maplewood, LLC	100.00%	305,524	305,524	3
4	V	31	Amortization		Maplewood, LLC	100.00%	6,667	6,667	4
5	V	36	Assignment Fee Expense		Maplewood, LLC	100.00%	9,920	9,920	5
6	V	21	Late Fee Expense		Maplewood, LLC	100.00%	1,271	1,271	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,076,929			\$ 1,445,775	\$ * 368,846	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,454	\$ 1,454	15
16	V	6 REPAIRS AND MAINT.	18,276	S.I.R. MANAGEMENT, INC.	100.00%	6,849	(11,427)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	780	780	17
18	V	10 NURSING	40,200	S.I.R. MANAGEMENT, INC.	100.00%	19,427	(20,773)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,288	3,288	19
20	V	17 ADMINISTRATIVE	71,232	S.I.R. MANAGEMENT, INC.	100.00%	7,747	(63,485)	20
21	V	19 PROFESSIONAL FEES	16,440	S.I.R. MANAGEMENT, INC.	100.00%	2,384	(14,056)	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,104	1,104	22
23	V	21 CLERICAL & GENERAL	20,712	S.I.R. MANAGEMENT, INC.	100.00%	26,270	5,558	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	598	598	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,671	2,671	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	588	588	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,926	4,926	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	5,493	5,493	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,253	3,253	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,115	3,115	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,651	6,651	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 166,860			\$ 96,598	\$ * (70,262)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

MAPLEWOOD CARE, INC.

0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger		4	5 Cost to Related Organization		6	7		8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	3	HOUSEKEEPING	\$	PREFERRED BOOKKEEPING		100.00%	\$ 613	\$	613	15	
16	V	5	UTILITIES		PREFERRED BOOKKEEPING		100.00%	827		827	16	
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING		100.00%	510		510	17	
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING		100.00%	14,307		14,307	18	
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING		100.00%	1,903		1,903	19	
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING		100.00%	368		368	20	
21	V	21	CLERICAL		PREFERRED BOOKKEEPING		100.00%	47,506		47,506	21	
22	V	24	SEMINARS		PREFERRED BOOKKEEPING		100.00%	187		187	22	
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING		100.00%	651		651	23	
24	V	26	INSURANCE		PREFERRED BOOKKEEPING		100.00%	417		417	24	
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING		100.00%	7,463		7,463	25	
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING		100.00%	3,049		3,049	26	
27	V	32	INTEREST		PREFERRED BOOKKEEPING		100.00%	1,190		1,190	27	
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING		100.00%	1,539		1,539	28	
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING		100.00%	2,631		2,631	29	
30	V										30	
31	V										31	
32	V	19	ACCOUNT/BOOKKEEPING	88,408	PREFERRED BOOKKEEPING		100.00%			(88,408)	32	
33	V	19	COMPUTER	4,872	PREFERRED BOOKKEEPING		100.00%	4,875		3	33	
34	V										34	
35	V										35	
36	V										36	
37	V										37	
38	V										38	
39	Total			\$ 93,280				\$ 88,036	\$ *	(5,244)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	\$ 20,712	S.I.R. MANAGEMENT, INC.	100.00%	\$ 5,609	\$ (15,103)
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	944	944
17	V	17	ADMIN./LEGAL SALARIES	43,676	S.I.R. MANAGEMENT, INC.	100.00%	89,483	45,807
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	12,227	12,227
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	12,327	12,327
20	V							
21	V							
22	V	10A	SPECIAL REHAB	0	S.I.R. MANAGEMENT, INC.	100.00%	0	
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	0	
24	V							
25	V							
26	V	6	REPAIRS AND MAINT.	17,964	S.I.R. MANAGEMENT, INC.	100.00%	12,502	(5,462)
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	2,177	2,177
28	V							
29	V							
30	V	1	DIETICIAN SALARIES	13,200	S.I.R. MANAGEMENT, INC.	100.00%	7,123	(6,077)
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,231	1,231
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$ 95,552			\$ 143,623	\$ *	48,071

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

MAPLEWOOD CARE, INC.

0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	22 EMPLOYEE HEALTH INS.	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 91,653	\$ 91,653	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INS.	91,653	CCS EMPLOYEE BENEFIT GROUP	100.00%		(91,653)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 91,653			\$ 91,653	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V	19 PROFESSIONAL FEES	\$	ECM OWNERS COUNCIL	100.00%	\$ 18	\$	18	15
16	V	20 DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	12		12	16
17	V	21 CLERICAL		ECM OWNERS COUNCIL	100.00%	26		26	17
18	V	26 INSURANCE		ECM OWNERS COUNCIL	100.00%	22		22	18
19	V	32 INTEREST		ECM OWNERS COUNCIL	100.00%	17		17	19
20	V	35 VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	312		312	20
21	V	17 MANAGEMENT FEES	4,320	ECM OWNERS COUNCIL	100.00%			(4,320)	21
22	V								22
23	V	17 ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	8,970		8,970	23
24	V	27 EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	522		522	24
25	V	17 ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%	(27)		(27)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 4,320			\$ 9,872	\$ *	5,552	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	4	5	6	7	8	
Schedule V	Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 ENTERAL EQUIPMENT	\$ 1,591	PARAMOUNT HEALTH CARE SYSTEMS	100.00%	\$ 259	\$ (1,332)	15
16	V	10 ENTERAL EQUIPMENT	4,812	PARAMOUNT HEALTH CARE SYSTEMS	100.00%	313	(4,499)	16
17	V	1 NUTRITIONAL SUPPLEMENTS		PARAMOUNT HEALTH CARE SYSTEMS	100.00%	3,591	3,591	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 6,403			\$ 4,163	\$ * (2,240)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **MAPLEWOOD CARE, INC.**# **0040428**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **MAPLEWOOD CARE, INC.**# **0040428**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLEWOOD CARE, INC. # 0040428 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Stockholder	Administrative	25.74	See Attached	4.84	9.68	Alloc Sal	\$ 28,282	17-7	1
2	Mike Giannini	Stockholder	Administrative	10.41	See Attached	4.3	8.60	Alloc Sal/Fees	25,871	17-7	2
3	Louise Bergthold	Stockholder	Administrative	5.91	See Attached	5.92	10.76	Alloc Sal	18,297	17-7	3
4	Joey Abramchik	Stockholder	Administrative	2.46	See Attached	5.38	10.76	Alloc Fees	12,227	17-7	4
5	Tom Winter	Stockholder	Administrative	0.74	See Attached	6.04	10.07	Alloc Sal	14,307	17-7	5
6	Stuart Sikes	Stockholder	Administrative	0.99	See Attached	4.3	10.75	Alloc Fees	11,287	17-7	6
7	Jeff Oravec	Stockholder	Administrative	0.49	See Attached	4.3	10.75	Alloc Sal	7,524	17-7	7
8	Arturo Rominquit	Relative	Clerical		See Attached	4.03	10.08	Alloc Sal	2,200	21-7	8
9	Nenita Guzman	Relative	Dietary		See Attached	5.92	10.76	Alloc Sal	5,609	1-7	9
10	Eric Rothner	Relative	Administrative	0.00	See Attached	0.68	0.94	Alloc Sal	7,201	17-7	10
11	Bill Brotzman	Stockholder	Administrative	2.96	0	40	100.00	Admin Sal	60,174	17-1	11
12											12
13								TOTAL	\$ 192,979		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

PREFERRED BOOKEEPING SERVICES

Street Address

4100 WEST PRATT AVE.

City / State / Zip Code

LINCOLNWOOD, IL. 60712

Phone Number

(847) 674-5200

Fax Number

(847) 674-5267

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	878,492	11	\$ 6,088	\$	88,408	\$ 613	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	878,492	11	8,220		88,408	827	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	878,492	11	5,069		88,408	510	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	878,492	11	142,165	142,165	88,408	14,307	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	878,492	11	18,910		88,408	1,903	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	878,492	11	3,657		88,408	368	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	878,492	11	472,061	403,426	88,408	47,506	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	878,492	11	1,858		88,408	187	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	878,492	11	6,465		88,408	651	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	878,492	11	4,146		88,408	417	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	878,492	11	74,163		88,408	7,463	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	878,492	11	30,298		88,408	3,049	12
13	32	INTEREST	BOOK./ACCNT.INCOME	878,492	11	11,823		88,408	1,190	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	878,492	11	15,297		88,408	1,539	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	878,492	11	26,147		88,408	2,631	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						4,875	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 826,367	\$ 545,591		\$ 88,036	25

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.I.R. MANAGEMENT, INC.Street Address 6840 N. LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number (847) 675 -7979Fax Number (847) 675 -0555

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	10	\$ 13,508	\$	69,183	\$ 1,454	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	10	63,644	42,834	69,183	6,849	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	10	7,250		69,183	780	3
4	10	NURSING	PATIENT DAYS	10	180,529	180,529	69,183	19,427	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	10	30,553		69,183	3,288	5
6	17	ADMINISTRATIVE	PATIENT DAYS	10	71,994	71,994	69,183	7,747	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	10	22,153		69,183	2,384	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	10	10,256		69,183	1,104	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	10	244,124	177,193	69,183	26,270	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	10	5,556		69,183	598	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	10	24,821		69,183	2,671	11
12	26	INSURANCE	PATIENT DAYS	10	5,468		69,183	588	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	10	45,778		69,183	4,926	13
14	30	DEPRECIATION	PATIENT DAYS	10	51,045		69,183	5,493	14
15	32	INTEREST	PATIENT DAYS	10	30,234		69,183	3,253	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	10	28,948		69,183	3,115	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	10	61,803		69,183	6,651	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 897,664	\$ 472,550		\$ 96,598	25

Facility Name & ID Number **MAPLEWOOD CARE, INC.**# **0040428**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization S.I.R. MANAGEMENT, INC.Street Address 6840 N. LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number (847) 675 -7979Fax Number (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	642,911	10	\$ 52,122	\$ 52,122	69,183	\$ 5,609	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	642,911	10	8,770		69,183	944	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	642,911	10	831,558	831,558	69,183	89,483	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	642,911	10	113,620		69,183	12,227	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	642,911	10	114,558		69,183	12,327	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	56,277	56,277			8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	\$ 9,470	\$		\$	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	237,604	10	165,366	165,366	17,964	12,502	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	237,604	10	\$ 28,790	\$	17,964	\$ 2,177	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	67,672	67,672	13,200	7,123	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	11,698		13,200	1,231	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,459,901	\$ 1,172,995		\$ 143,623	25

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 4101 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION		\$	\$		\$ 91,653	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 91,653	25

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

ECM OWNERS COUNCIL

Street Address

6840 N. LINCOLN

City / State / Zip Code

LINCOLNWOOD, IL. 60646

Phone Number

(847) 676-2026

Fax Number

()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC. 96,000	9	\$ 400	\$	4,320	\$ 18	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC. 96,000	9	264		4,320	12	2
3	21	CLERICAL	ECMOC MGMNT FEE INC. 96,000	9	579		4,320	26	3
4	26	INSURANCE	ECMOC MGMNT FEE INC. 96,000	9	496		4,320	22	4
5	32	INTEREST	ECMOC MGMNT FEE INC. 96,000	9	374		4,320	17	5
6	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC. 96,000	9	6,931		4,320	312	6
7									7
8									8
9	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS 39	9	81,858	81,858	4	8,970	9
10	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS 39	9	4,762		4	522	10
11	17	ADMIN. SALARY	DIRECT ALLOCATION					(27)	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 95,664	\$ 81,858		\$ 9,872	25

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization PARAMOUNT HEALTH CARE SYSTEMS
 Street Address 6300 OAKTON
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847)470-4700
 Fax Number (847)470-4718

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	ENTERAL EQUIPMENT	DIRECT ALLOCATION					259	1
2	10	ENTERAL EQUIPMENT	DIRECT ALLOCATION					313	2
3	1	NUTRITIONAL SUPPLEMENTS	DIRECT ALLOCATION					3,591	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 4,163	25

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **MAPLEWOOD CARE, INC.**# **0040428**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	CIB Bank/S.I.R. Line		X	WORKING CAPITAL				1,525,000				118,416	6
7	STOCKHOLDER LOAN	X										1,617	7
8	INSURANCE FINANCING		X	Insurance Premiums								2,358	8
9	TOTAL Facility Related						\$	1,525,000			\$	122,391	9
	B. Non-Facility Related*												
10	Supplemental Schedule											1,126,853	10
11	Interest Income											(33)	11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	1,126,820	14
15	TOTALS (line 9+line14)						\$	1,525,000			\$	1,249,211	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number

MAPLEWOOD CARE, INC.

0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
1	Alloc From Mplwd LLC	X					\$					\$ 1,122,393	1
2	Alloc From Pref. Bkpg	X										1,190	2
3	Alloc From ECM Owners Cncl.	X										17	3
4	Alloc From SIR Management	X										3,253	4
5													5
6													6
7													7
8													8
9													9
10													10
11													11
12													12
13													13
14													14
15													15
16													16
17													17
18													18
19													19
20													20
21							\$					\$ 1,126,853	21

Facility Name & ID Number **MAPLEWOOD CARE, INC.**# **0040428** Report Period Beginning: **01/01/00** Ending: **12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	82,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	89,848	2
3. Under or (over) accrual (line 2 minus line 1).	\$	7,048	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	88,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	95,248	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	78,493	8
	1996	79,660	9
	1997	79,254	10
	1998	80,608	11
	1999	85,194	12

2000 Accrual = 1.035*1999 Expense Rounded to \$88,200				
Total 2000 Taxes Paid = Maplewood Care \$85,194 + Alloc SIR Mgt \$3,115+Alloc Pref. Bkpg \$1,539				

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number MAPLEWOOD CARE, INC.

0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,780 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1993</u>	<u>\$ 517,253</u>	1
2					2
3	TOTALS			\$ 517,253	3

Facility Name & ID Number **MAPLEWOOD CARE, INC.**# **0040428**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	203		1993		\$ 9,827,799	\$ 251,995	35	\$ 280,794	\$ 28,799	\$ 2,141,055	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1993		98,204	3,050	20	3,593	543	29,791	9
10	Various		1994		13,684		20	684	684	5,050	10
11	Various		1995		5,179	298	20	259	(39)	1,415	11
12	AIR CONDITIONERS		1996		19,800	2,281	20	990	(1,291)	4,785	12
13	WATER HEATER		1997		7,992	921	20	400	(521)	1,533	13
14	ROOM DIVIDERS		1997		1,632	188	20	82	(106)	280	14
15	4 ELECTRIC HEATERS		1997		10,637	1,225	20	532	(693)	2,084	15
16	KITCHEN SUPPRESSOR		1997		1,427	164	20	71	(93)	278	16
17	DRAPES		1998		2,572		20	129	129	312	17
18	HEATING & COOLING		1998		1,100		20	55	55	115	18
19	ROOM DIVIDERS		1998		5,674	1,294	20	284	(1,010)	592	19
20	DRAPES		1998		1,370		20	69	69	167	20
21	PAINTING		1998		878		20	44	44	103	21
22	BUILDING EXHAUST FANS		1998		1,204		20	60	60	125	22
23	WATER CONDITIONER		1998		1,500	270	20	75	(195)	213	23
24											24
25	PAGE 12-1 REP TOTALS				85,877	3,548		3,343	(205)	18,858	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				241,801	22,097		10,224	(11,873)	11,826	34
35	PAGE 12A TOTALS				375,088	9,602		17,370	7,768	18,747	35
36	TOTAL (lines 4 thru 35)				\$ 10,703,418	\$ 296,933		\$ 319,058	\$ 22,125	\$ 2,237,329	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **MAPLEWOOD CARE, INC.**# **0040428**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		HOT WATER HEATER		1998	2,679		20	134	134	290	9
10		ROOF DRAINS		1998	2,100		20	105	105	263	10
11		FLOORING		1999	1,364		20	68	68	74	11
12		HOT WATER HEATER		1999	4,778		20	239	239	458	12
13		REMODELING		1999	11,357	291	20	568	277	710	13
14		HVAC ROOFTOP		1999	3,076		20	154	154	180	14
15		HVAC WORK		1999	2,035		20	102	102	136	15
16		HVAC WORK		1999	2,405		20	120	120	150	16
17		WATER HEATER		1999	1,132		20	57	57	114	17
18		HVAC WORK		1999	7,410		20	371	371	680	18
19		FIRE DOOR		1999	1,494		20	75	75	150	19
20		WALK IN REPAIR		1999	672		20	34	34	68	20
21		HVAC WORK		1999	1,693		20	85	85	113	21
22		HVAC ROOFTOP		1999	9,070		20	454	454	530	22
23		HVAC REPAIR		1999	542		20	27	27	54	23
24		PAINTING		2000	14,259	229	20	475	246	475	24
25		FLOORING		2000	18,304	371	20	763	392	763	25
26		THERMOSTAT		2000	1,088		20	50	50	50	26
27		FLOORING		2000	31,252	634	20	1,303	669	1,303	27
28		PASS ELEVATOR		2000	34,890	709	20	1,454	745	1,454	28
29		RESIDENT FURN		2000	13,289	2,658	20	1,108	(1,550)	1,108	29
30		PAINTING		2000	40,751	827	20	1,698	871	1,698	30
31		PAINTING		2000	21,202	521	20	1,060	539	1,060	31
32		PAINTING		2000	46,688	1,147	20	2,334	1,187	2,334	32
33		PAINTING		2000	33,775	830	20	1,689	859	1,689	33
34		FLOORING		2000	31,716	576	20	1,190	614	1,190	34
35		PAINTING		2000	36,067	809	20	1,653	844	1,653	35
36		TOTAL (lines 4 thru 35)			\$ 375,088	\$ 9,602		\$ 17,370	\$ 7,768	\$ 18,747	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **MAPLEWOOD CARE, INC.**# **0040428**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NURSE STATION FURN			2000	9,502	1,901	20	871	(1,030)	871	9
10	ROOM DIVIDERS			2000	35,870	7,174	20	1,346	(5,828)	2,692	10
11	WINDOW TREATMENTS			2000	26,479	5,296	20	1,765	(3,531)	1,765	11
12	CARPETING			2000	3,163	633	20	105	(528)	210	12
13	FLOORING			2000	4,210	59	20	123	64	123	13
14	FIRE DAYERS			2000	45,200	531	20	1,130	599	1,130	14
15	HVAC SLEEVE			2000	1,367	274	20	40	(234)	80	15
16	CARPETING			2000	1,000	200	20	38	(162)	76	16
17	WINDOW TREATMENTS			2000	2,499	500	20	73	(427)	146	17
18	GAS AND ELECTRIC			2000	1,452		20	6	6	6	18
19	FLOORING			2000	18,304	332	20	686	354	686	19
20	PAINTING			2000	14,885	302	20	620	318	620	20
21	FLOORING			2000	60,142	1,349	20	2,756	1,407	2,756	21
22	NURSE STATION			2000	17,728	3,546	20	665	(2,881)	665	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 241,801	\$ 22,097		\$ 10,224	\$ (11,873)	\$ 11,826	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
21												
22												
23												
24												
25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **MAPLEWOOD CARE, INC.**# **0040428**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993	SIR Prop-PB	\$ 14,210	\$ 451	35	\$ 406	\$ (45)	\$ 3,045	4
5			1993	SIR Prop-MGT	28,754	913	35	822	(91)	6,162	5
6											6
7											7
8											8
	Improvement Type**										
9		Allocation From SIR Management	1993		12,350	410	20	623	213	4,867	9
10		Allocation From SIR Management	1994		39		20	4	4	25	10
11		Allocation From SIR Management	1995		282	16	20	14	(2)	76	11
12		Allocation From SIR Management	1999		1,341	89	20	67	(22)	81	12
13		Allocation From SIR Management	2000		810	88	20	28	(60)	28	13
14		Allocation From SIR Properties - SIR Management	1993		466	25	20	23	(2)	175	14
15		Allocation From SIR Properties - SIR Management	1994		274	7	20	14	7	89	15
16		Allocation From SIR Properties - SIR Management	1997		108	11	20	5	(6)	24	16
17		Allocation From SIR Properties - SIR Management	1998		1,741	174	20	87	(87)	218	17
18		Allocation From SIR Properties - SIR Management	1999		3,644	364	20	182	(182)	273	18
19		Allocation From Preferred Bookkeeping	1997		17,747	669	20	887	218	3,380	19
20		Allocation From Preferred Bookkeeping	1999		141	45	20	7	(38)	11	20
21		Allocation From Preferred Bookkeeping	2000		890		20	19	19	19	21
22		Allocation From SIR Properties - Preferred Bookkeeping	1993		230	12	20	12		86	22
23		Allocation From SIR Properties - Preferred Bookkeeping	1994		135	3	20	7	4	44	23
24		Allocation From SIR Properties - Preferred Bookkeeping	1997		54	5	20	3	(2)	12	24
25		Allocation From SIR Properties - Preferred Bookkeeping	1998		860	86	20	43	(43)	108	25
26		Allocation From SIR Properties - Preferred Bookkeeping	1999		1,801	180	20	90	(90)	135	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36		TOTAL (lines 4 thru 35)			\$ 85,877	\$ 3,548		\$ 3,343	\$ (205)	\$ 18,858	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **MAPLEWOOD CARE, INC.**# **0040428**

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 794,886	\$ 86,597	\$ 79,342	\$ (7,255)		\$ 471,763	37
38	Current Year Purchases	183,124	36,474	14,991	(21,483)		15,216	38
39	Fully Depreciated Assets	121,705	8,732	501	(8,231)		121,705	39
40								40
41	TOTALS	\$ 1,099,715	\$ 131,803	\$ 94,834	\$ (36,969)		\$ 608,684	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 12,320,386	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 428,736	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 413,892	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (14,844)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 2,846,013	51

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

MAPLEWOOD CARE, INC.
0040428
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Mapplewood Care, Inc	124,504	28,420	12,452	(15,968)	37,187
Mapplewoood Care, LLC	609,000	53,529	60,900	7,371	395,850
Allocation Preferred Bookkeeping	20,616	1,476	1,913	437	12,644
Allocation SIR Management	40,726	3,172	4,073	901	26,052
Allocation SIR Properties - SIR Management	27		3	3	20
Allocation SIR Properties - Preferred Bookkeeping	13		1	1	10
TOTALS	794,886	86,597	79,342	(7,255)	471,763

LINE 29: CURRENT YEAR

Mapplewood Care, Inc	181,247	36,131	14,879	(21,252)	15,104
Mapplewoood Care, LLC					
Allocation Preferred Bookkeeping	600	120	50	(70)	50
Allocation SIR Management	1,277	223	62	(161)	62
Allocation SIR Properties - SIR Management					
Allocation SIR Properties - Preferred Bookkeeping					
TOTALS	183,124	36,474	14,991	(21,483)	15,216

LINE 30: FULLY DEPRECIATED

Mapplewood Care, Inc	121,705	8,732	501	(8,231)	121,705
Mapplewoood Care, LLC					
Allocation Preferred Bookkeeping					
Allocation SIR Management					
Allocation SIR Properties - SIR Management					
Allocation SIR Properties - Preferred Bookkeeping					
TOTALS	121,705	8,732	501	(8,231)	121,705

TOTALS (Should Tie to Totals on Page 13)

Mapplewood Care, Inc	427,456	73,283	27,832	(45,451)	173,996
Mapplewoood Care, LLC	609,000	53,529	60,900	7,371	395,850
Allocation Preferred Bookkeeping	21,216	1,596	1,963	367	12,694
Allocation SIR Management	42,003	3,395	4,135	740	26,114
Allocation SIR Properties - SIR Management	27		3	3	20
Allocation SIR Properties - Preferred Bookkeeping	13		1	1	10
TOTALS	1,099,715	131,803	94,834	(36,969)	608,684

Facility Name & ID Number MAPLEWOOD CARE, INC.# 0040428

Report Period Beginning:

01/01/00Ending: 12/31/00**XII. RENTAL COSTS****A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease .9. Option to Buy: ☐ YES ☐ NO Terms: ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES☐ NO16. Rental Amount for movable equipment: \$ 6,614Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2001 Chevy G10 Van	\$ 433.00	\$ 3,189	17
18	Alloc ECM Owners Council			312	18
19	Alloc Pref. Bookkpg			2,014	19
20	Alloc SIR Mgt.			6,397	20
21	TOTAL		\$ 433.00	\$ 11,912	21

10. Effective dates of current rental agreement:

Beginning Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ 13. /2002 \$ 14. /2003 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number

MAPLEWOOD CARE, INC.

#

0040428

Report Period Beginning:

01/01/00

Ending:

12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☒ YES☐ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☒

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 473
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				85
9	TOTALS	\$	\$	\$	\$ 558
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your
facility received training aides from other facilities.\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 26,588	\$		\$ 26,588	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			930			930	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			44,798			44,798	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				19,094		19,094	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
	**SEE SUPPLEMENTAL									
13	Other (specify): SCHEDULE**					748	10,862		11,610	13
14	TOTAL			\$		\$ 73,064	\$ 29,956	\$	103,020	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 Medical Supplies	3,100
2 Enteral Supplies	2,067
3 Equipment Rental	5,472
4 Lab	223
5	
6	
7	
8	
9	
10	
	<u>10,862</u>
<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 Respiratory Therapy	748
2	
3	
4	
5	
6	
7	
8	
9	
10	
	<u>748</u>

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 72,348	\$ 72,449	1
2 Cash-Patient Deposits	30,681	30,681	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,039,121	1,039,121	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	6,322	6,322	6
7 Other Prepaid Expenses	2,631	2,631	7
8 Accounts Receivable (owners or related parties)		2,040	8
9 Other(specify): See supplemental schedule		58,449	9
TOTAL Current Assets			
10 (sum of lines 1 thru 9)	\$ 1,151,103	\$ 1,211,693	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		517,253	13
14 Buildings, at Historical Cost		9,827,799	14
15 Leasehold Improvements, at Historical Cos	550,341	550,341	15
16 Equipment, at Historical Cost	637,896	1,246,896	16
17 Accumulated Depreciation (book methods)	(379,110)	(2,575,432)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):	507,500	507,500	22
23 Other(specify): See supplemental schedule		161,291	23
TOTAL Long-Term Assets			
24 (sum of lines 11 thru 23)	\$ 1,316,627	\$ 10,235,648	24
TOTAL ASSETS			
25 (sum of lines 10 and 24)	\$ 2,467,730	\$ 11,447,341	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 203,509	\$ 203,509	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	34,769	34,769	28
29 Short-Term Notes Payable	1,525,000	1,525,000	29
30 Accrued Salaries Payable	192,011	192,011	30
31 Accrued Taxes Payable (excluding real estate taxes)	11,451	11,451	31
32 Accrued Real Estate Taxes(Sch.IX-B)	29,751	88,200	32
33 Accrued Interest Payable	4,630	4,630	33
34 Deferred Compensation			34
35 Federal and State Income Taxes	6,000	6,000	35
Other Current Liabilities(specify):			
36 See supplemental schedule		20,300	36
37			37
TOTAL Current Liabilities			
38 (sum of lines 26 thru 37)	\$ 2,007,121	\$ 2,085,870	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 See supplemental schedule		11,712,910	43
44			44
TOTAL Long-Term Liabilities			
45 (sum of lines 39 thru 44)	\$	\$ 11,712,910	45
TOTAL LIABILITIES			
46 (sum of lines 38 and 45)	\$ 2,007,121	\$ 13,798,780	46
47 TOTAL EQUITY (page 18, line 24)	\$ 460,609	\$ #REF!	47
TOTAL LIABILITIES AND EQUITY			
48 (sum of lines 46 and 47)	\$ 2,467,730	\$ #REF!	48

*(See instructions.)

STATE OF ILLINOIS

Page 17 SUPP-1

Facility Name & ID Number MAPLEWOOD CARE, INC.

0040428

Report Period Beginning: 01/01/00

Ending:

12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES

As of 12/31/00

OTHER CURRENT ASSETS:

Real Estate Tax Escrow

Amount

Amount

58,449

OTHER CURRENT LIABILITIES:

Due to Maplewood Care

Amount

Amount

20,300

58,449

20,300

OTHER NON CURRENT ASSETS:

Intangible - Net

Prepaid Assignment Fee

Option Deposit

56,664

84,327

20,300

161,291

OTHER NON CURRENT LIABILITIES:

Capital Lease Obligation

Tenant Security Deposit

11,225,710

487,200

11,712,910

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 83,294	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 83,294	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	377,315	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 377,315	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 460,609	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number	MAPLEWOOD CARE, INC.	#	0040428	Report Period Beginning:	01/01/00	Ending:	12/31/00
---------------------------	----------------------	---	---------	--------------------------	----------	---------	----------

Balance per General Ledger	83,294
----------------------------	--------

Adjustments:

-
-
-

Total adjustments

-

Balance - Beginning of Year

83,294

Equity(Deficit) from Page 17 Col 1

460,609

Related Party

Equity(Deficit)

Income

-2443202

-368846

(2,812,048)

Combined Equity - End of Year

(2,351,439)

Facility Name & ID Number MAPLEWOOD CARE, INC.

0040428

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,589,423	1
2	Discounts and Allowances for all Levels	(161,286)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,428,137	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	167,480	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 167,480	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	51,424	13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs	21,939	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,310	19
20	Radiology and X-Ray		20
21	Other Medical Services	10,944	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 85,617	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	33	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 33	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	293	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 293	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,681,560	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,158,008	31
32	Health Care	2,498,933	32
33	General Administration	1,019,318	33
	B. Capital Expense		
34	Ownership	1,413,518	34
	C. Ancillary Expense		
35	Special Cost Centers	103,020	35
36	Provider Participation Fee	111,448	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,304,245	40
41	Income before Income Taxes (line 30 minus line 40)**	377,315	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 377,315	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? [No Cash Basis](#) If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

DESCRIPTION	AMOUNT
1 Pay Phone Commisions- Adjusted out on p. 5	293
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	293

Facility Name & ID Number **MAPLEWOOD CARE, INC.**

0040428

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,832	2,091	\$ 62,994	\$ 30.13	1
2	Assistant Director of Nursing	1,970	2,081	49,637	23.85	2
3	Registered Nurses	20,366	22,608	447,059	19.77	3
4	Licensed Practical Nurses	7,320	7,732	133,218	17.23	4
5	Nurse Aides & Orderlies	60,943	62,508	593,830	9.50	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,512	12,833	121,910	9.50	8
9	Activity Director	1,903	2,091	55,350	26.47	9
10	Activity Assistants	11,015	11,675	34,643	2.97	10
11	Social Service Workers	12,226	13,163	139,424	10.59	11
12	Dietician					12
13	Food Service Supervisor	1,897	2,091	39,513	18.90	13
14	Head Cook	6,329	6,505	52,545	8.08	14
15	Cook Helpers/Assistants	17,286	17,758	112,501	6.34	15
16	Dishwashers					16
17	Maintenance Workers	2,453	2,742	39,403	14.37	17
18	Housekeepers	30,757	31,957	229,746	7.19	18
19	Laundry	4,492	5,083	35,586	7.00	19
20	Administrator	1,857	2,092	60,174	28.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,493	8,263	96,246	11.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,146	4,418	69,732	15.78	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	206,797	217,691	\$ 2,373,511 *	\$ 10.90	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	\$ 1,599	01-3	35
36	Medical Director	MONTHLY	6,000	09-3	36
37	Medical Records Consultant	96	4,032	10-3	37
38	Nurse Consultant	MONTHLY	40,200	10-3	38
39	Pharmacist Consultant	36	1,800	10-3	39
40	Physical Therapy Consultant	MONTHLY	5,788	10A-3	40
41	Occupational Therapy Consultant	MONTHLY	4,274	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	MONTHLY	95	10A-3	43
44	Activity Consultant	53	2,454	11-3	44
45	Social Service Consultant	52	2,567	12-3	45
46	Other(specify) <u>Psycho Social</u>	48	2,224	12-3	46
47	<u>Director of Food Service</u>	MONTHLY	20,712	01-3	47
48	<u>Dietician</u>	MONTHLY	13,200	01-3	48
49	TOTAL (lines 35 - 48)	285	\$ 104,945		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	6,931	\$ 241,197		50
51	Licensed Practical Nurses				51
52	Nurse Aides	19,615	373,284		52
53	TOTAL (lines 50 - 52)	26,546	\$ 614,481		53

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
		\$	\$
<u>0</u>	<u>0</u>	\$ <u>0</u>	\$ <u>#DIV/0!</u>

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
<u>BILL BROTZMAN</u>	<u>ADMINISTRATOR</u>	<u>2.96</u>	<u>\$ 60,174</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 25,994</u>		<u>IDPH License Fee</u>	<u>\$ 200</u>
				<u>Unemployment Compensation Insurance</u>	<u>18,443</u>		<u>Advertising: Employee Recruitment</u>	<u>19,923</u>
				<u>FICA Taxes</u>	<u>179,521</u>		<u>Health Care Worker Background Check</u>	<u>732</u>
				<u>Employee Health Insurance</u>	<u>53,992</u>		(Indicate # of checks performed <u>61</u>)	
				<u>Employee Meals</u>	<u>26,747</u>		<u>Alloc - ECM Owners Council</u>	<u>12</u>
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>			<u>Dues, Subscriptions, License, and Fees</u>	<u>5,882</u>
				<u>Employee Benefits</u>	<u>23,257</u>		<u>Alloc - SIR Management</u>	<u>1,104</u>
							<u>Advertising and Promotion</u>	<u>15,631</u>
							<u>Yellow Page Advertising</u>	<u>5,010</u>
							<u>Alloc - Pref. Bkpg.</u>	<u>368</u>
							Less: Public Relations Expense	()
							<u>Non-allowable advertising</u>	<u>(15,631)</u>
							<u>Yellow page advertising</u>	<u>(5,010)</u>
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 60,174				TOTAL (agree to Sch. V, line 20, col. 8)	\$ 28,221
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)	\$ 327,954		G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Service Fees - See Attached Schedule</u>			<u>\$ 71,232</u>			<u>\$</u>	<u>Out-of-State Travel</u>	<u>\$</u>
<u>Management Fees - See Attached Schedule</u>			<u>47,996</u>					
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 119,228					
C. Professional Services								
Vendor/Payee	Type		Amount					
<u>S.I.R. Management</u>	<u>Dir. Of Reg. Services</u>		<u>\$ 16,440</u>					
<u>Preferred Bookkeeping</u>	<u>Accounting</u>		<u>20,200</u>					
<u>Frost, Ruttenberg & Rothblatt</u>	<u>Accounting</u>		<u>22,515</u>					
<u>Preferred Bookkeeping</u>	<u>Computer Support</u>		<u>4,872</u>					
<u>Preferred Bookkeeping</u>	<u>Bookkeeping</u>		<u>68,208</u>					
<u>Personnel Planners</u>	<u>Unemployment Tax Consult.</u>		<u>1,560</u>					
<u>Mid America Programming</u>	<u>MDS Software</u>		<u>1,320</u>					
<u>ICS Solutions</u>	<u>Internet Web Site</u>		<u>175</u>				<u>Seminar Expense</u>	<u>3,132</u>
<u>Legal Fees</u>	<u>See Attached Schedule</u>		<u>47,907</u>				<u>Alloc - Preferred Bookkeeping</u>	<u>187</u>
							<u>Alloc - SIR Management</u>	<u>598</u>
							<u>Entertainment Expense</u>	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 183,197	TOTAL		\$	TOTAL	\$ 3,917
(If total legal fees exceed \$2500 attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Paint & Def Maintenace	06/97	\$ 4,983	3	\$ 831	\$ 1,661	\$ 1,661	\$ 830	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 4,983		\$ 831	\$ 1,661	\$ 1,661	\$ 830	\$	\$	\$	\$	\$

Facility Name & ID Number MAPLEWOOD CARE, INC.

0040428

Report Period Beginning: 01/01/00

Ending: 12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. \$5759 - IL Council on LTC
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 111,447
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 26,747 Has any meal income been offset against related costs? NA Indicate the amount. \$ NA
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw